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ABSTRACT

This manual assists state agencies in developing public policy and programs to address prevention and treatment for the abuse of alcohol and other drugs by women during pregnancy. It stresses the importance of collaborative action among the many agencies involved. The first chapter is a specific call for collaboration, noting several federal programs which emphasize collaboration. The second chapter discusses three specific state service systems in terms of their missions, mandates, and structures, responsibilities, and relationship to federal agencies and support. They are Maternal and Child Health Bureau services, substance abuse services, and child welfare. Other state agencies and groups are also considered (e.g., Medicaid, mental health, and corrections). The third chapter identifies four stages of development in establishing an interagency approach: (1) formation, (2) conceptualization, (3) development, and (4) implementation. Each stage is illustrated by the experiences of communities and organizations serving families affected by alcohol and other drug use. A list of 12 guidelines for establishing collaboration is offered. Appendices list state Title V directors, state alcohol and drug agency directors, and state child welfare commissioners/directors. (Contains 29 references.) (DB)

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PROMOTING STATE INTERAGENCY EFFORTS TO REDUCE THE IMPACT OF PERINATAL ALCOHOL AND OTHER DRUG USE ON FAMILIES

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FINDING COMMON GROUND

A Call for Collaboration

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PROMOTING STATE INTERAGENCY EFFORTS TO REDUCE THE IMPACT OF PERINATAL ALCOHOL AND OTHER DRUG USE ON FAMILIES

Virginia H. Jones, M.D., and
Ellen Hutchins, M.S.W., M.P.H.

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INTRODUCTION

The use of alcohol and other drugs by women during pregnancy is perceived by many to be a growing problem in the United States. Maternal use of alcohol and other drugs increases the risk of developmental disability for infants and children.[1] It profoundly affects not only the mother and child but also other family members and the community. Successful response to alcohol and other drug use demands coordination among the multiple service providers who interact with afflicted and at-risk individuals. The sheer number of families struggling with addiction coupled with the need for a communitywide response has impacted professionals in different agencies in their attempts to achieve consensus on effective prevention and intervention strategies.

This manual is offered as a resource for staff of State agencies for use in developing public policy and programs to address prevention and treatment. Because success in this arena requires attention to all aspects of well-being and self-sufficiency, we stress cooperation among agencies at a minimum and encourage truly collaborative action rather than fragmented services. The myriad of agencies responsible for services includes maternal and child health, alcohol and other drug prevention and treatment services, child welfare, education, mental health, housing, and corrections. Each plays an integral role in addressing the problem of substance abuse and dependency as it influences families. Consumer advocacy groups, businesses, professionals, elected officials, foundations, local leadership, and consumers should work with these agencies to jointly define the problem and appropriate responses.

State agency staff can play a vital role in formulating public policy around issues related to the use of harmful substances by women of childbearing age. The exact nature and extent of alcohol and other drug use varies from community to community as do the resources available to meet the needs of affected individuals. Clearly, local communities must be responsible for designing and providing services which are accessible and acceptable in their particular environment. Yet State agencies are frequently sources of the monetary and informational base and leadership which enable or limit local groups. It is critical, therefore, that State agencies model a collaborative approach to the prevention, treatment, and rehabilitation of women, children, and families involved with alcohol and other drugs.

CHAPTER

1

THE CALL FOR COLLABORATION

No single agency or system of services can respond effectively to the complex needs presented by those involved in or at risk for alcohol and other drug dependency.[2] The categorical nature of service programs demands parallel interagency cooperation at the Federal, State, and local levels if coherent approaches to alcohol and other drug use prevention and intervention are to be planned, implemented, and evaluated.

Notable among the recommendations of several recent national commissions has been the call for interagency cooperation around the issues of perinatal alcohol and other drug use prevention. The North American Commission on Chemical Dependency and Child Welfare, convened by the Child Welfare League of America, the National Commission on Children, and the National Commission to Prevent Infant Mortality, have all recognized the need for united efforts to effectively reduce the impact of perinatal alcohol and other drug use.[3,4,5] Such acknowledgment is drawn from the experiences of those working directly with affected women, children, and families who struggle against fragmented, inadequate, and prejudicial service systems.

Fortunately, interagency collaboration is not a new concept. Federal legislation over the past decade has mandated multi-agency planning and programming in a number of overlapping arenas. The Medicaid (Title XIX) and Maternal and Child Health (Title V) Programs have been directed to establish formal agreements, to share outreach responsibilities, and to coordinate resources for the purpose of reducing infant mortality and morbidity.[6] In deliberating the most recent amendments to part H of the Individuals with Disabilities Act, Congress hailed interagency collaboration around early intervention for children with developmental disabilities as a new paradigm for systems operation.[7]

One example of interagency cooperation at the Federal level is the relationship between the Maternal and Child Health Bureau (MCHB) of the

Health Resources and Services Administration (HRSA) and the Center for Substance Abuse Prevention (CSAP) within the Substance Abuse and Mental Health Services Administration (SAMHSA).* Integrated programming has been pursued by the two agencies through cooperative policy development, the sharing of staff and other resources, and the mutual funding of substance abuse prevention activities that relate to pregnant women and children. The CSAP and MCHB together have guided the development and implementation of the Pregnant, Postpartum Women and Their Infants demonstration grants as well as the National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs.

Also pertinent to collaboration within the field of perinatal alcohol and other drug use prevention is the Federal Healthy Start program launched in 1991. Fifteen communities across the Nation have been funded to develop a consortia of agencies, both public and private, and including the business community to focus on infant mortality reduction. Many Healthy Start projects focus on reducing perinatal alcohol and other drug use. Healthy Start communities will also test the effectiveness of community coalitions as agents of change, provide models of collaboration, and delineate the breadth of agencies addressing infant mortality reduction.

The Head Start Program, the CSAP Community Partnership Grants, several individual grants awarded through the Office of Special Education Programs within the U.S. Department of Education, and the special projects of regional and national significance (SPRANS) awarded through the MCHB are other examples of collaborative Federal efforts that address reduction of perinatal alcohol and other drug use among their goals.

Staff in many State agencies already work collaboratively to prevent maternal alcohol and other drug use, primarily by establishing task forces or commissions. The valuable experiences gained by these groups can contribute richly to ongoing collaborative interagency work. The following chapters describe the process of interagency collaboration, highlighting frequent barriers and tools for overcoming those barriers. Awareness of and attention to the process of establishing collaboration will increase the likelihood that interagency efforts will have a positive effect on the reduction of alcohol and other drug use on women, children, and families.

** As of October 1, 1992, the Office for Substance Abuse Prevention (OSAP) became CSAP within SAMHSA.*

CHAPTER

2

RELEVANT STATE AGENCIES

Leadership in addressing the problem of perinatal alcohol and other drug use has come from officials in executive, legislative, judicial, and administrative branches of State governments. As State agency staff come together to establish a mutual agenda, they realize that they each represent strong organizational, professional, and personal identities. The consequences of inadequate knowledge about the various agencies working with families who are affected by drugs include duplication of services, underuse of valuable expertise, and mistrust. Not coincidentally, these are also organizational motives for seeking interagency action. An appreciation for differences in agency histories, missions, legislative mandates, funding requirements, and operating mechanisms can ease developing common ground for action.

This chapter will focus on the background and activities of the State service systems most prominently involved in reducing the impact of alcohol and other drug use on families. Several types of agencies will be mentioned, since many resources must be assembled to implement effective prevention and intervention strategies.

THREE STATE SERVICE SYSTEMS: THEIR MISSIONS, MANDATES, AND EXPERIENCES

Maternal and Child Health Bureau
The Mission

Established in 1935 as part of the Social Security Act, Title V (Maternal and Child Health Bureau) remains the only national Federal program devoted exclusively to maternal and child health services. Title V provides not only a Federal statutory basis for maternal and child health services in each State and territory, but also important resources to support the infrastructure for those services.[8] The Title V mandate is extremely broad, i.e., to improve the health of all mothers and children. Special attention, however, is directed to low-income families, families with limited access to care, and families with children who have special health needs due to chronic or disabling conditions. Strategies often used to promote maternal and child health—such as outreach to isolated and otherwise hard-to-reach populations, home visiting, identification of high-risk health conditions, and assurance of access to risk appropriate care—are highly relevant to the needs of women and children involved with alcohol and other drug use.

The Federal Mandate

The current framework of maternal and child health was created in 1981 when the Maternal and Child Health Services Program, the Children with Special Health Care Needs Program,* and additional categorical programs targeting mothers, children, and/or youth were consolidated into the Maternal and Child Health (MCH) Services Block Grant. Each State receives block grant funds distributed through the Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service (PHS), U.S. Department of Health and Human Services (DHHS), according to a set formula.

In amending the Title V legislation through the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Congress established specific guidelines for the use of MCH Block Grant funds, and for planning and reporting by the States.† Through the support of statewide system

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* *The title* Children With Special Health Care Needs *replaced that of the Crippled Children's Program in 1986.*
† *Sec. 501. (a) of the Social Security Act.*

development and direct support of community services, State Title V agencies are required to:

1. Assure access to quality, community-based preventive and primary care for pregnant women, infants, children, and youth, as well as specialized health care and family support services for children with special health needs;
2. Conduct comprehensive needs assessment and planning;
3. Develop family-centered, coordinated, community-based systems;
4. Enhance interagency coordination; and
5. Submit an annual report.

Perinatal alcohol and other drug use are pertinent to each of these categories of activities.

The discretionary portion of MCH Block Grant funding supports a variety of demonstration, research, training, and services grant programs known as special projects of regional and national significance (SPRANS grants). One particular category, initiated in 1992, is the Community Integrated Service System (CISS) grants which support demonstration projects related to home visiting, provider participation, integrated service delivery, nonprofit hospital MCH centers, rural programs, and community projects for children with special health needs. While not solely focused on the needs of families affected by alcohol and other drugs, these grants do foster advances in service delivery which are critical in meeting the needs of such families.

State Structure and Responsibilities

At the State level, Title V MCH programs must be administered by the State health agency. Because of historical arrangements, however, Children with Special Health Care Needs (CSHCN) programs in 10 States are located in another agency or university. As is true for other State systems, the structural relationships of the maternal and child health program to the Governor's office, to other State agencies, and to local health agencies varies from State to State. OBRA '89 requires each State to maintain its contribution to MCH funding at or above fiscal year 1989 levels. Beyond requirements to spend at least 30 percent of program funds on preventive and primary care for children, at least 30 percent on children with special health

needs, and no more than 10 percent on administrative needs, States have significant discretion in determining the nature of their programs consistent with documented need assessment.

The responsibilities of State Title V MCH agencies in systems development and direct service provision are germane to perinatal alcohol and other drug issues. Activities aimed at building the capacity of the health care system may include the following: the recruitment of providers willing to serve pregnant women, infants, and children who are affected by alcohol and other drug use; instructing providers about alcohol and drug assessment; developing models of early intervention that incorporate home visiting and case management; and strengthening linkages with other State and local agencies serving women and children.

Direct services provided or funded by State MCH agencies emphasize primary and preventive care, such as the reproductive health needs of women, risk-appropriate prenatal care, and health supervision for children and youth. Those children with special health needs are served with a focus on comprehensive care that is family centered and community based.

As part of their annual reporting, States are required to document the number of newborns with fetal alcohol syndrome and drug dependency. Related information also collected includes infant mortality rates, low birthweight rates, the availability of services, and the number of women and infants covered by Medicaid or insurance.[9]

Hotlines for parents to learn about Medicaid and MCH providers are another requirement of MCH programs. MCH programs must establish written agreements with the State Medicaid agency that defines how both agencies will identify pregnant women and children who are eligible for Medicaid and assist them in application procedures. The substance of these existing agreements, the process of interagency communication used to negotiate the agreements, and the resulting interagency relationships offer successful efforts on which to build coordination around substance abuse issues. For example, staff of other State agencies can benefit by contacting their Title V Director and learning what specific MCH support exists in their State for outreach, education, data collection, service provision, and community coordination on behalf of women of childbearing age, their children, and their families. (*See* appendix A on page 37 for a current listing of State Title V Directors.)

Substance Abuse Services
The Mission

In the Alcohol, Drug Abuse, and Mental Health Services Administration (ADAMHA) Reorganization Act of 1992, the Congress reconstituted the Substance Abuse and Mental Health Services Administration (SAMHSA) with a series of new responsibilities. First among them is to "establish and implement a comprehensive program to improve prevention and treatment related services to individuals with substance abuse and mental illness; improve prevention services; promote mental health and protect the legal rights of both substance abusers and the mentally ill."[10] The needs of women and high-risk youth are particularly emphasized. The importance of coordination with other systems is underscored as the Act directs SAMHSA to "collaborate with the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA) to promote integration of substance abuse into mainstream health care."[11]

The Federal Structure

In the early 1980s, seven Federal programs for alcohol, drug abuse and mental health services were consolidated into the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant to be administered by the ADAMHA. This major Federal funding initiative for alcohol and other drug services at the State level has supported "planning, establishment and evaluation of prevention, treatment and rehabilitation services."[11] The Anti-Drug Abuse Acts of 1986 (P.L. 99-570) and 1988 (P.L. 100-690) focused activity on the prevention of substance abuse, the latter by establishing the Office for Substance Abuse Prevention (OSAP) within the ADAMHA.[12] The need to support the development of State and community infrastructures around substance abuse services resulted in the creation of the Office for Treatment Improvement (OTI) in 1990. It is this entity which has administered the ADMS Block Grant to the States in recent years, providing technical assistance for improving treatment services and centralizing information on State operations.

With the creation of SAMHSA, various responsibilities have been redistributed among three Centers: the Center for Substance Abuse Prevention (CSAP), formerly OSAP; the Center for Substance Abuse Treatment (CSAT), formerly OTI; and the Center for Mental Health Services

(CMHS), a new agency. Women, children, and families, community systems and coordination are given high priorities by the CMHS, with the aim of strengthening prevention and treatment efforts.

Under the Act, the research programs of the National Institute on Drug Abuse (NIDA), the National Institute on Alcoholism and Alcohol Abuse (NIAAA), and the National Institute of Mental Health (NIMH) are now part of the National Institutes of Health (NIH). A large part of SAMHSA's role is administering the categorical demonstration projects; these include client-oriented grant programs, systems development grant programs, substance abuse treatment capacity building grants, and training grants. Requirements for multi-agency coordination and treatment expansion for special populations are a feature of each grant program. Grantees within each State have the potential to contribute significantly to the increased availability of services and advancement of the state of the art.

State Structure and Responsibilities

It is important for members of a State agency consortium to understand not only current structure but also agency histories. Today, all State alcohol and other drug programs are combined under common State statutes. Alcohol and other drug programs, however, may have been originally established in separate agencies with differing missions and later merged by State legislation. Such legislation may dictate structural organization, but it does not always assure the development of a common mission and cohesive programming. Likewise, the creation of SAMHSA sets into motion State program adjustments that may take several years to mature.

Title II of the ADAMHA Reorganization Act of 1992 realigned the ADMS Block Grant into two block grants: one for substance abuse and the other for mental health. Many States will relate to the two block grants through separate substance abuse and mental health agencies. As under the ADMS Block Grant prior to the Act, States must maintain funding for alcohol and drug abuse services and for primary prevention activities. They also must address tobacco products and tobacco use, particularly among minority populations. The Women's Set-Aside has been restructured exclusively for pregnant women. States must show a 5 percent increase in their capacity to serve pregnant women and women with dependent children during each of the next 2 years.

Several provisions of the Act will lead State alcohol and drug agencies into coordination with other State agencies. For example, each treatment program receiving funds under the block grant must directly—or through arrangements with other providers—make prenatal and child health care available for all participants. Tuberculosis and HIV screening, testing, counseling, and access to treatment services must be available in States with AIDS case rates of 10 per 100,000 or greater. Pregnant women seeking alcohol and other drug treatment must be given preference; this policy must be publicized.

State agencies receiving block grants have a specific responsibility to "coordinate various services and activities . . . with other appropriate services including health, social [services], corrections and criminal justice, education, vocational rehabilitation and employment." Whether in regard to training of professionals, public awareness campaigns, developing interagency agreements, or conducting needs assessment, other State agencies have overlapping Federal mandates and, more importantly, experience that is valuable to State alcohol and drug agencies as they respond to new block grant provisions. (*See* appendix B on page 55 for a current listing of State Alcohol and Drug Agency Directors.)

Child Welfare

The child welfare system is less uniform in its structure from State to State than those presented above. In contrast to the definition of a system as "units which function interdependently and harmoniously," the Child Welfare League of America (CWLA) points out that the child welfare system is loosely composed of hundreds of State and county child welfare and family service agencies and thousands of independent, private agencies.[13] Services provided by this array of public and private sources strengthen and support families, prevent child abuse and neglect, and mitigate stressful environmental conditions, such as violence and poverty, which ultimately threaten children and families. The increased involvement of families with alcohol and other drug use has made it more difficult for agency staff to meet these goals.

The Mission

Briefly stated, the mission of the child welfare system is to promote and protect the well-being of children, doing so to the greatest extent possible within the context of the family. In the report entitled *Children at the Front—A Different View of the War on Alcohol and Drugs*, the CWLA lists eight major areas of responsibility for agencies serving the child welfare system: (1) protecting and promoting the well-being of all children; (2) supporting families and preventing abuse, neglect, exploitation, and delinquency; (3) promoting family stability; (4) placing children in appropriate out-of-home care when they are jeopardized by remaining with the family; (5) assuring adequate services to children in out-of-home placement; (6) providing services toward family reunification; (7) providing adoption services when reunification is not possible; and (8) proactively identifying and ameliorating social conditions that negatively impact on children.[13]

Federal Funding Sources

Funding for aspects of child welfare come from several Federal sources. The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services distributes monies under Title IV-B of the Social Security Act to specific State agencies to subsidize State child welfare service costs. Title IV-E is allocated for State costs related to Aid to Families with Dependent Children (AFDC) eligible children in need of foster care. Although Title XX of the Social Security Act can theoretically provide funds for crisis intervention with children, in practice the funds are too limited to meet this demand. The ACF also makes funding available to States through the National Child Abuse and Neglect grants and the Abandoned Infants Assistance grants (for children at risk of abandonment because of substance abuse exposure or HIV status).

Community Implementation of Child Welfare

The Adoption Assistance Act of 1980, P.L. 96-272, established the mandate that determines child welfare practice today. At the time of its passage, the Act presented a bold, new concept to child welfare: that the well-being of children was best protected and promoted when their needs were

considered within the context of the family. The law instructs agencies to make "reasonable efforts" to maintain family unity and work for reunification when temporary foster placement is necessary.

Progress towards these goals has been hampered by a number of interrelated factors which have strained the child welfare system during the past decade. There has been a dramatic upswing in reported cases of child abuse and neglect. Increasing numbers of children and families live in poverty with limited access to essential health and human services. Neither the human nor the financial resources necessary to protect these vulnerable children or strengthen their families has been available. Further, the recent surge of crack cocaine use among women of childbearing age and its impact on families has resulted in more children requiring out-of-home care.

There is uneven interpretation and implementation of P.L. 96-272 at the State and local levels, hampering its effectiveness. Vaguely defined terms, such as "reasonable efforts," have been subject to differing interpretations by juvenile courts, State legislatures, and child welfare administrators. New protocols for protecting and promoting child well-being and family stability need to be developed and integrated into the efforts of the entire community.[13] For children who cannot remain at home, the array of options should include temporary and permanent placement, kinship care, foster care, residential out-of-home care, and adoption. Indeed, the provision of all services to children and families should be based on need and not on availability.

Issues for Cross-Agency Coordination

The Twelve Step National Policy Agenda proposed by the CWLA's North American Commission on Chemical Dependency and Child Welfare is replete with recommendations requiring interagency coordination for effective implementation, such as:

1. A system of comprehensive health care for all children and families which includes alcohol and drug treatment;
2. The establishment of culturally appropriate, neighborhood-based family resource centers that offer a variety of child and adult services;
3. Increased support of interagency research into child abuse prevention;

4. The availability of family planning services, human immunodeficiency virus (HIV) services, child care, outreach to the homeless, housing, employment services, and recreational services through coordination of existing resources; and
5. Cross-training of agency staff, professionals, and caregivers.[13]

Also proposed are activities to strengthen the ability of communities to meet the eight areas of responsibility listed earlier (*see* appendix C on page 63 for the current listing of State Child Welfare Commissioners/Directors).

Other State Agencies and Groups

Maternal and child health, alcohol and other drug prevention and treatment, and child welfare agencies are by no means the only agencies working to reduce the impact of drug and alcohol dependency on women of childbearing age, their children, and their families. Virtually any agency that serves families can contribute to collaborative efforts which address the problem of perinatal alcohol and other drug use. Since no single agency can meet the complex, interrelated needs of addicted individuals, collaboration among agencies is imperative. Prevention efforts will not be as effective if they are scattered and narrowly focused. Following is a portrayal of other agencies having significant impact on perinatal alcohol and other drug use. Each should participate as challenges are discussed and responses considered.

Medicaid

Initially passed in 1965 as Title XIX of the Social Security Act, Medicaid was intended to provide the poor with access to health care. The Health Care Financing Administration within the DHHS is responsible for oversight of this program which is administered by each State. States have been allowed varying degrees of freedom in defining the parameters of their own Medicaid programs within broad Federal guidelines. Again, interagency participants should be aware of their own State Medicaid plan and the State legislation that guides it.

Since 1984, Congress has taken Medicaid through a series of changes which has decoupled Medicaid from the Aid for Families with Dependent Children program, broadened the array of available services, and lowered income thresholds for eligibility for pregnant and postpartum women and their children. As a result of these amendments and increases in the number

of women and children in poverty, some States are already reporting that 50 percent of their births are being covered by Medicaid.[14] This percentage could continue to climb as incremental eligibility admits older children to coverage through the year 2001.

Underlying the eligibility and service package changes for mothers and children has been a major change in philosophy. Medicaid is now seen as an opportunity to prevent infant mortality and morbidity by improving access to prenatal, postpartum, and child health care. Rather than enforcing eligibility criteria which limit the number of individuals likely to qualify for Medicaid, officials have engaged in outreach, case management, and mandated coordination with other agencies and programs in efforts to find, enroll, and serve eligible women and children.

As of July 1992, 40 States have expanded the range of services available to Medicaid-eligible pregnant women.[15] Such services include risk assessment in which drug and/or alcohol dependency figure prominently. A determination of high-risk status triggers intensified prenatal, obstetric, and postpartum services. Medicaid may even cover inpatient detoxification for a limited number of days.

Through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid, infants and children have access to health care services for the purpose of detecting and treating conditions which negatively impact a child's physical, developmental and emotional well-being. There is great potential in this program to serve children known to have been prenatally exposed to drugs or those who carry no such diagnosis but manifest related difficulties.

Efforts are under way in a number of States and at the national level to use Medicaid as a vehicle to supplement the funding of drug and alcohol treatment for those who are eligible, with special emphasis being given to women and children. In one study, the General Accounting Office (GAO) found that "Despite the variety of services covered, multiple barriers exist that limit the States' ability to expand the use of Medicaid as a treatment resource. Federal law, policies, insufficient State funds and provider reluctance to accept some clients are all barriers to expansion."[16] Even with present limits on coverage of alcohol and other drug-dependency related conditions, Medicaid stands as a powerful tool in securing health care, transportation, case management, and mental health services for pregnant women and children affected by alcohol and other drug use.

Mental Health

The role of mental illness as a condition frequently co-existing with alcohol and other drug dependency has been increasingly recognized. Within the SAMHSA, the new Center for Mental Health Services (CMHS) was created on an administrative level equivalent to substance abuse prevention and substance abuse treatment.[11] The ADMS Block Grant has now been clearly split into two distinct block grants, one for substance abuse and one for mental health. The latter will now be administered by the Center for Mental Health Services.

Although both Substance Abuse Services and Mental Health Services fall under the same agency at the Federal level, this is not necessarily true at the State level. Yet the role of the State Mental Health Agency in statewide planning and activities for families affected by alcohol and other drugs is important in regard to women who may have dual diagnoses. It is also applicable in providing early intervention for children either prenatally exposed to alcohol or other drugs or growing up in a family struggling with addiction.

Mental Retardation/Developmental Disabilities

Fetal alcohol syndrome is considered to be the leading preventable cause of mental retardation in this country.[17] Increasing knowledge about the relationship between prenatal consumption of alcohol and birth defects highlights interagency opportunities for prevention and early intervention. In regard to alcohol, tobacco, illicit substances, or other medications and products, both professionals and the general public require continuing education about the risks of abuse, prevention strategies, and the need for prompt identification of and intervention with those affected.

Whether from direct toxic exposure prenatally, environmentally imposed risk, or a combination of those factors, developmental delay is a significant problem for children who are affected by alcohol and other drugs.[18] Through State-sponsored programs and local boards, adults and children can receive diagnostic services and some treatment services. Staff in agencies that serve those with developmental disabilities are important in the identification and referral of at-risk individuals and family members. The services they provide will be most effective when offered within the context of the comprehensive services needed by families affected by alcohol and other drug use.

Education

Prevention programs have been a focal point for school systems across the country. In regard to women of childbearing age and young children, the educational system plays an equally important role in identification, early intervention, and supportive services.

The Individuals with Disabilities Education Act (P.L. 99-457) and its recent amendments (P.L. 102-119) support the educational readiness of young children by establishing a system of early intervention services from birth through entry into school. The paradigm of systems coordination that has developed through early intervention services is tailor-made for the child at risk for developmental delay because of prenatal or environmental exposure to drugs or alcohol. Both Part H of the Act (children ages birth through 2 years) and Part B (children ages 3 to 5 years) call for the integration of health, social, and educational services as part of individualized planned response and demand that such plans be family centered. The best opportunities for assuring appropriate coordinated services for affected children are instituting early intervention services and making children at risk for developmental delay eligible.

Head Start programs offer another opportunity for identifying the drug-affected child and family intervention. Based on the successful involvement of parents in Head Start, vigorous efforts are under way to support those parents who may be struggling with addiction.[19]

As drug and alcohol dependent parents are rehabilitated, attainment of educational skills which allow meaningful employment are a must. Adolescent parenting programs, G.E.D. certificate programs, job training, and job development are being increasingly incorporated into community demonstration models to encourage and sustain self-sufficiency; these provide excellent opportunities for collaboration among agencies.

Corrections

Significant numbers of incarcerated pregnant and parenting mothers and fathers are dependent on alcohol and other drugs. Unfortunately, incarceration often means lack of basic health care, risk-appropriate prenatal care, and drug and alcohol treatment.[20] Agency staff note that incarcerated parents often lack information about the harmful side effects of substance abuse, personal health care, and parenting. At the same time, they have found

parents to be receptive to education and other services—even without coercion. The high-risk populations of men and women residing in prison are in need of the attention of maternal and child health providers, child welfare workers, alcohol and other drug treatment providers, and others in obtaining services necessary for health, recovery, and family reunification.

Juvenile Services

There appear to be strong associations among adolescent pregnancy, dropping out of school, chronic legal entanglements, and alcohol and drug abuse. Youth involved with juvenile justice systems are at high risk for each of these situations. Juvenile justice officials and institutional staff may be eager to coordinate with State agency staff members around the health, treatment, and educational needs of youth in the system. Ideally, a State interagency consortium will involve juvenile justice authorities not only in designing treatment programs for incarcerated youth, but also in prevention and early intervention efforts. Such collaboration offers the hope of reducing the number of first-time offenders and recidivism rates. It also enhances an understanding of the complex needs of adolescents by staff from each of the State agencies who interact with adolescents.

Elected Officials

Depending on their ownership of the problem, the legislative and executive branches of State government will be either partners or adversaries in accomplishing the goals of a State coalition. Ultimately, they dictate final goals. It is wise, therefore, to include them as active members of the consortia. Staff members from the Governor's office and the Attorney General's office, as well as members of the State legislature, their aides, and others, should participate in cross-training opportunities, in studies of the problems, in constructing recommendations, and in implementing responses.

Other Groups

The above discussion centers on those State agencies in which staff are most likely to encounter families involved with substance abuse. In developing statewide plans and programs, representation from or liaison with other agencies and organizations may be productive. State agencies dealing

with economic development influence community policies regarding the advertisement of tobacco and alcohol products, and can target employment programs toward particularly disadvantaged groups. The input and involvement of professional organizations, the business community, and grass-roots organizations should be incorporated at all levels of activity.

When asked about barriers to early success, consortia members with experience in addressing the needs of families affected by alcohol and other drug use have stated that not identifying and bringing all involved agencies to the table at the onset of the process had been their greatest stumbling block.[21] State officials are urged to heed this lesson and to draw together the participants for creating a service system that truly responds to the needs of such families. As the consortia matures, there will be opportunities to broaden membership even further. Diversity in consortia membership will enhance ownership of the problems and solutions and will lend greater creativity to the programs devised. The benefits are worth the energy required to blend the concerns and styles of additional agency representatives.

CHAPTER

3

ESTABLISHING COLLABORATIVE EFFORTS

Several aspects of alcohol and other drug use among women of childbearing age and their families thwart attempts by single providers or even single agencies to effectively serve them.

First, rehabilitation of a mother or intervention with a drug-affected child demands the attention of the multiple service systems that serve them in our society. Experience in community-based projects is showing that the entire family unit plays a role in either motivating its members toward recovery or propelling them further into addiction and dependency. A second common observation is that addiction gradually shreds any organization in the lives of those who are alcohol or drug dependent, presenting them with seemingly insurmountable legal, financial, and social problems. The current inadequacy of resources and the opportunity to lessen the impact of harmful substances on families now demand that agencies combine their energies.

Thoughtful planning and implementation are often viewed as a hindrance to urgent action. Lessons learned through other collaborative efforts have shown that guiding the process of collaboration actually conserves time spent across multiple organizations and provides a road map for constant adaptation of activities to changing environments.

In establishing an interagency approach, four stages of development can be described: formation, conceptualization, development, and implementation.[22] Each stage is characterized by a specific set of tasks which can be illustrated using the experiences of communities and organizations active in serving families affected by alcohol and other drug use.

Formation
Membership

The message from long-standing consortia bears repeating: Not identifying and bringing all potential agencies to the table at the onset of the process had been their greatest stumbling block.[21] Assembling a large membership may seem unwieldy, but early involvement in a group is critical to full participation in problem identification and resolution. Those agencies left out may actually be a hindrance to achieving consortia goals.

Broad membership will also allow balanced policy and program development. Any one agency or profession is likely to view substance abuse within the context of their own training and experience. For example, health professionals may focus heavily on the content of prenatal or child health care, while failing to ensure appropriate maternal alcohol or other drug treatment. Those concerned with the provision of alcohol and other drug treatment for the mother may fail to recognize the significance of co-existing mental illness. Without specific training on the cause and consequences of addiction and dependency, child welfare workers may be critical of a mother's needs. Blending agency and professional perspectives begins in mutual examination of the problem and continues with planning, implementation, and evaluation.

As the interagency group assembles, it should be aware of the potential for overlap in purpose and authority. Maternal substance abuse may be seen as part of the responsibility of alcohol and drug agency services, as an issue for health planning, or as a concern of child welfare. Each agency is likely to have initiatives addressing more global concerns. The interagency group will need to clarify its sphere of concern as related to individual agency activities.

Group Structure

Answering questions about the organizational structure of the interagency group may guide invitations to participate. How long is the group to function? If the intent is to institutionalize the group, can organizations and businesses outside State government be included as equal partners? Is participation in highly structured meetings the only way for consumers of services to contribute to the partnership?

Existing interagency collaborative efforts, such as Healthy Mothers, Healthy Babies coalition, have been used successfully to launch State and

community efforts. Through already existing organizations, administrative resources can be conserved and community acceptance of new activities around perinatal addiction facilitated.

State and Local Community Relationships

The relationship between the State interagency group and local communities will be determined in part by the existing State agency structure. For example, in some States, local health departments are units of the State agency with budget, policy, and programming emanating from the State agency. In other States, local health departments are largely autonomous and directed by local elected or appointed boards. The independence of such local agencies means that their participation will depend upon their perception of mutual benefit coming out of the interagency group.

Regardless of the State-local relationship, the community should be the focal point of planning and support since it is at the neighborhood level that programming can best respond to local alcohol and other drug usage patterns, service availability, and cultural differences. During the past decade, work around early intervention for children has shown that State interagency groups can learn and benefit from innovation at the local level. In Missouri, the State-level interagency group participants believe they are able to better monitor and adapt the effectiveness of their policies because they maintain close contact with local agencies providing direct services to their target population.[23]

Leadership

Leadership for the interagency group will also depend on membership and will influence group structure. Membership, leadership, and structure of an interagency group may already be established by State law. It is common for a single lead agency to be selected so that responsibility for group process can be clearly assigned.[24] Not all believe this is desirable, however, with some preferring a shared authority.[25] Sharing or rotating leadership allows each agency to provide direction to the group and brings recognition to their particular area of expertise and responsibility.

Conceptualization
Establishing a Mission and Philosophy

Definition of a unified mission statement and philosophy is the first task of a newly assembled interagency group. The relative importance of supportive vs. punitive approaches, designation of special populations to be served, and beliefs about various modes of prevention and treatment are but a few of the issues which may stir debate among members. Since early commitment to the group will be fostered by early success, it is important to adopt principles on which there seems to be a high level of agreement. Divisive issues can be negotiated more easily after some group identity and trust has been established.

In Ohio, the Task Force on Drug-Exposed Infants immediately adopted a preliminary set of guiding philosophical statements to set itself apart from the myriad of other legislative, judicial, and criminal justice commissions already in existence.[26] Task force members acknowledged that further investigation and potential solutions might result in a change of direction for the group. Still, the philosophy statements established an identity that attracted debate, and generated information and invitations to publicly explore perinatal substance abuse issues.

Building Consensus

Several barriers to consensus building need to be identified and overcome. The interface between agencies is similar to that of different cultures. Specific "language" or jargon exists in each agency culture, along with unique perspectives on the problem, specific Federal or State mandates, etc. Just as effective translation of language must be literal and conceptual, so too translation across agencies and between staff of different professional backgrounds must account for terminology, definitions, and perspectives. For example, the definition of "prevention" in one system may refer only to activities that prevent first use, while other systems may apply prevention to aspects of early intervention and rehabilitation as well.

Another significant barrier to consensus is resistance to change. Agency staff should be wary of such resistance in themselves, from their own agencies as the group moves ahead in its understanding of the issues, and from the outside as recommendations for change are made and pursued. Moderating the threats inherent in change is often possible. Some interagency groups

have approached this by scheduling quarterly updates for their agency directors or through ongoing training sessions for agency staff not participating directly in group activities.

A method increasingly used to improve understanding among agencies is cross-training of staff. Federal agencies, several communities, and some States have "loaned" agency staff to each other either for a period of time or to work on a specific interagency project. The result has been increased appreciation for the resources, constraints, and policies among the agencies involved in exchange and improved program coordination. If exchanging staff is not possible, interagency group meetings can be rotated among the physical settings of member agencies or group members can participate in site visits to agency projects in the field.[27,28]

Needs Assessment

Each agency joins the partnership with different understandings of the problem, its own information sources and data, which may or may not be comparable to the data of other agencies. After an initial listing of questions to be answered and while early consensus is being gained on group goals and objectives, agencies can identify information available to each. Definitions of data elements, the cost and personnel resources required to access data, and the compatibility of information management systems must be clear in order to judge its availability.

The usefulness of data lies in understanding its limitations. Both data elements and the systems which manipulate the data contribute to the accuracy of information obtained. All members of the State interagency group should strive to reach a common level of understanding of these limitations so that they speak the same language in analyzing and responding to the data.

Data inform all steps of the coordination process. They are needed to define the common problem(s) uniting the State interagency group, to formulate goals and objectives, to quantify and qualify results, and to support evaluation. Once the interagency group has acquired a preliminary understanding of the extent of perinatal substance use-related problems—such as the number of women who use alcohol or other drugs during pregnancy, and what the ideal situation might be—they can formulate measurable goals and objectives. The specificity of the goals and objectives

may be driven by existing State plans, by legislative or regulatory mandate, or by community expectations for information. Evaluation of group success in meeting their objectives may lead to refinement or adjustment of objectives and a gradual maturation of the needs assessment process.

Evaluation

The foundation for evaluation of group efforts should be established early in the group's organizational development. Records of the process and progress should be kept from the group's first formation. Consortia functioning over several years report the importance of being able to reflect back on group successes, even those that seemed minor at the time.[26] Evaluation of outcomes depends on knowledge of the conditions at the outset of group efforts and the degree to which goals and objectives are met. After choosing indicators and tools to measure progress, the group members must constantly examine the data they have collected and reassess whether they are measuring what they initially intended.

Development

During the third stage of interagency consortia growth, working groups and communication networks are established. Certain committees and communication patterns will have developed earlier, during the stages of formation and conceptualization. Upon completion of the needs assessment, however, the consortia moves into a period of intense activity as it determines potential activities and prioritizes them.

Communications

Committees may focus their work on individuals within the family, on various service needs, or on functional issues, such as legislative concerns, confidentiality, or mechanisms of interagency coordination. Regardless of how the work is divided, committee issues will overlap. A clear pattern of information sharing and planning should be established among group members. Arrangements for necessary sign-off from agency directors and other authorities should be thought through ahead of time.

Given the public visibility of the issue and of most State agency groups, communication with advocates, the news media, and other interested parties should be well-planned. Regular media contact can avert premature criticism

of the group's efforts and actually build community support. Sunshine laws* applying to public agencies may allow media representatives more knowledge of consortia activities than the group desires; however, the consortia should be prepared for their presence.

Even while the consortia is in developmental stages, the support of advocacy groups should be nurtured. Local consortia and consumers are especially important in this regard. In two-way exchange, the public can be both informed and their input sought through public hearings—a rich source of information about community attitudes and services.

There are several vehicles for communication throughout the life of the consortium. Newsletters can relay brief updates on consortia membership, requests for information or contacts. Consortia members may serve as presenters at conferences or training seminars where they have an opportunity to advance the agenda of the consortium. Provision of testimony on related legislation even before recommendations are finalized may be critical, given the somewhat unpredictable timetable for bill passage. Support gained as the consortium proceeds with its work will serve to strengthen its ability to accomplish system changes in a timely manner.

Cooperation vs. Collaboration

At this point in its life, the consortium will also be facing decisions about the extent to which members are willing to integrate services. Terminology describing the stages of interagency relations is evolving. In this document, coordination refers to any stage of interagency effort across the full range of possibilities. The Education and Human Services Consortium, Washington, D.C., draws a clear distinction between cooperation and collaboration.[29] Cooperation allows multiple agencies to meet their respective organizational goals, to assess the need for more comprehensive services, and coordinate existing services without changes in the basic services or in agency policies and regulations. Budgets remain under the control of the parent agencies.

The interagency group functioning at a cooperative level should not consider themselves at an inferior starting point. Participating agencies may not be ready philosophically to move beyond cooperation, or they may not have the authority and resources to enter a collaborative effort. Better

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* *The term* sunshine law *often refers to laws which require government agencies or other publicly-subsidized entities to open to public scrutiny the information they gather, the documents they produce and all their operations. Exceptions are stipulated in law.*

understanding of the issues surrounding perinatal substance abuse, improvement in the quality of services, minimal duplication of services, and increased interagency referral of clients are a few of the benefits of cooperative activities.

Collaboration requires partners to relinquish total control of resources in favor of the group process. Resources are pooled while consortia members jointly plan, implement, and evaluate new services and procedures. Budgetary resource commitment is usually the acid test of agency buy-in to consortia activities. In order for this to occur, agency directors must be supportive of the consortium, and representatives to the consortium must be able to influence the redirection of policies, resources, and facilities in their own agencies. Cooperative activities which are successful will build tension towards increasingly collaborative efforts.

An example of collaboration can be seen in States which establish a single pooled fund drawn from the monies available to member agencies. The mechanism for disbursing funds, the activities to be funded, and the requirements for reporting are determined by group consensus.

Implementation

Written agreements and adapted policies become the concrete evidence that the consortium is ready to implement its plans. As legally binding commitments, memorandums of agreement among agencies test the willingness of the participants to move forward with plans. Because of existing Federal requirements, several member agencies may already have written agreements which address at least a portion of the services needed for prevention and intervention on behalf of families affected by alcohol and other drug use. Their experience in negotiating and executing those agreements are of benefit to the group. Indeed, existing agreements may require only an addendum to accomplish certain consortia goals.

The interagency consortium will realize success as policies, rules, and regulations of the parent agencies become consistent with the philosophy of the consortium. Unfortunately, the short life of task forces, lack of parent agency investment in consortia activities, and the instability of political environments often jeopardize even the best conceived plans. Community groups working under demonstration grants have found that it may take as long as 1 to 3 years after the development of goals, objectives, and an implementation plan to overcome unforeseen administrative, community,

and conceptual barriers. With frequent turnover in key cabinet posts, elected officials and other leaders whose support is critical to sustained consortia activity, interagency groups can easily loose momentum and disband. Therefore, the interagency group should identify mechanisms, such as legislation, for assuring continuity of successful collaborative activities.

Evaluation

Evaluation of movement toward consortia goals is a process that continually refines the mission, philosophy, and goals of the interagency group. It may result in consortia membership changes or adaptation of the organizational structure and leadership. The ultimate client outcomes related to decreased impact of drug and alcohol abuse on women, their children, and their families should dictate the necessity for consortia realignment.

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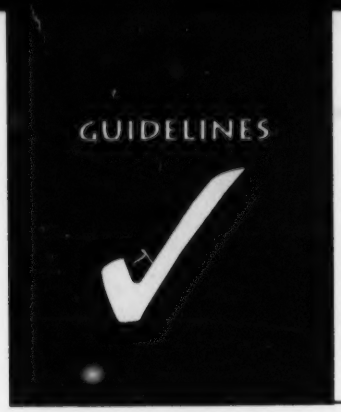

GUIDELINES FOR ESTABLISHING COLLABORATION

Although details of the collaborative process in each State will be as diverse as the families and communities being served, the organizational structures of involved agencies and the resources available, recommendations for successful group process are emerging from the work of Federal, State, and community agency staff who together have grappled with the issue of perinatal alcohol and other drug use. Lessons learned through trial and error are discussed in previous chapters but are summarized here as guidelines. They are offered as a springboard to policy and program development to more effectively and efficiently reduce the impact of alcohol and drug use on women, their children, and their families.

GUIDELINES

1 Successful response to perinatal alcohol and other drug use demands the coordination of services among multiple agencies and the professionals who interact with families affected by alcohol and other drug use.

2 Mutual appreciation for the differences in agency histories, missions, legislative mandates, funding requirements, and operating mechanisms can greatly ease developing common ground for action.

3 Deliberate guidance of the process of collaboration conserves the staff effort that is often invested in tasks that cross multiple agencies. It provides a road map for constant adaptation of activities to changing environments.

4 Early involvement of a broad membership is critical to full participation in problem identification and resolution. Failure to involve key agencies may hinder implementation of consortia goals.

5 The local community should be the focal point of State interagency planning and support, with community members informing the interagency process and providing evidence of its success.

6 Development of a unified mission statement and philosophy is the defining task of a newly established group.

7 Agency staff members serving on a consortium must be aware of interorganizational differences in language, terminology, and perspectives, and of both personal and organizational resistance to change.

8 Members of a consortium must allocate time for agency and discipline cross-training. The education process is continuous and will keep consortia members abreast of changes, trends, and emerging issues in all related fields.

9 An ongoing record of progress and a review of group successes will provide important motivation for the group as members struggle through the stages of development and implementation of coordinated service systems.

10 Existing interagency consortia dedicated to human service system change can provide templates on which to build interagency efforts to reduce the impact of alcohol and other drugs on families and communities.

11 Individual agency support of consortia efforts through funding and other resource sharing gives evidence of the level of commitment to consortia goals. It frequently parallels the maturing of agency relationships: The financing of early cooperative activities are controlled by individual agencies, while collaborative strategies are usually accomplished through pooled funds under the group's control.

12 Evaluation of movement towards consortia goals will allow continual refinement of mission, philosophy, goals, membership, structure, and leadership.

APPENDICES

APPENDIX A
State Title V Directors

ALABAMA

MCH Director
Larry O. Gulley
Deputy Director
Bureau of Family Health Services
Alabama Department of Public Health
434 Monroe Street, Room 381
Montgomery, AL 36130-1701
phone: (205) 242-5661
fax: (205) 269-4865

CSHN Director
Kay Herrin, M.S.W.
Coordinator
Children's Rehabilitation Service
Division of Rehabilitation Services
Alabama Department of Education
P.O. Box Box 11586
Montgomery, AL 36111-0586
phone: (205) 281-8780
fax: (205) 281-1973

ALASKA

MCH Director
Karen Pearson, R.D., M.S.
Chief
Section of Maternal, Child and Family Health
Alaska Department of Health and Social Services
1231 Gambell, Room 314
Anchorage, AK 99501-4627
phone: (907) 274-7626
fax: (907) 586-1877

CSHN Director
Debra Caldera, R.N., M.P.H.
Program Manager
Handicapped Children's Program
Alaska Department of Health and Social Services
1231 Gambell
Anchorage, AK 99501-4627
phone: (907) 272-1534
fax: (907) 277-6814

AMERICAN SAMOA

Diana Tuinei, R.N., M.P.H.
MCH/CSHN Director
Department of Health
Pago Pago, American Samoa 96799
phone: (684) 633-4606

ARIZONA

MCH Director
Jane Pearson, R.N.
Chief
Office of Women's and Children's Health
Division of Family Health Services
Arizona State Department of Health
1740 West Adams, Room 200
Phoenix, AZ 85007
phone: (602) 542-1870
fax: (602) 542-2789

CSHN Director
Lynda Miller
Chief
Office of Children's Rehabilitative Services
Arizona State Department of Health Services
1740 West Adams
Phoenix, AZ 85007
phone: (602) 542-1860
fax: (602) 542-2789

ARKANSAS

MCH Directors
Richard Nugent, M.D., M.P.H.
Medical Director
Section of Maternal and Child Health
Arkansas Department of Health
4815 West Markham, Slot #41
Little Rock, AR 72205
phone: (501) 661-2199
fax: (501) 661-2055

Donnie Smith
Administrative Director
Section of Maternal and Child Health
Arkansas Department of Health
4815 West Markham, Slot #41
Little Rock, AR 72205
phone: (501) 661-2199
fax: (501) 661-2055

CSHN Directors
Nancy Church, R.N.
Administrator
Children's Medical Services
Department of Human Services
P.O. Box 1437, Slot #526
Little Rock, AR 72203-1437
phone: (501) 682-2277
fax: (501) 682-8013

Gil Buchanan, M.D.
Director
Children's Medical Services
Arkansas Department of Human Services
500 South University, Suite 200
Little Rock, AR 72205
phone: (501) 664-4117
fax: (501) 664-1137

CALIFORNIA

Stephen W. Kessler
Acting Deputy Director
Primary Care and Family Health
California State Department of Health
714 P Street, Room 350
Sacramento, CA 95814
phone: (916) 654-0265
fax: (916) 657-0796

MCH Director
Rugmini Shah, M.D.
Chief
Maternal and Child Health Branch
California State Department of
Health Services
714 P Street, Room 750
Sacramento, CA 95814
phone: (916) 657-1347
fax: (916) 657-0796

CSHN Director
Maridee A. Gregory, M.D.
Chief
California Children's Medical Services
Branch
California State Department of Health
714 P Street, Room 323
P.O. Box 942732
Sacramento, CA 94234-7320
phone: (916) 654-0499
fax: (916) 657-0796

COLORADO

Daniel Gossert, A.C.S.W., M.P.H.
Director
Family Health Services Division
Colorado Department of Health
4210 East 11th Avenue
Denver, CO 80220
phone: (303) 692-2315
fax: (303) 782-5576

CONNECTICUT

Suzette Benn, R.N., M.P.A.
Acting Bureau Chief
Bureau of Community Health Services
State Department of Health Services
150 Washington Street
Hartford, CT 06106
phone: (203) 566-4282
fax: (203) 566-8401

MCH Director
John Huettner
Director
Division of Maternal and Infant Health
150 Washington Street
Hartford, CT 06106
phone: (203) 566-5601
fax: (203) 566-8401

CSHN Director
Nancy Zinneman Berger, M.P.H.
Director
Child and Adolescent Health Division
Bureau of Community Health
150 Washington Street
Hartford, CT 06106
phone: (203) 566-2520
fax: (203) 566-8401

DELAWARE

MCH Director
Sathyavathi Lingaraju, M.D., M.P.H.
Director
Maternal and Child Health
Division of Public Health
P.O. Box 637
Dover, DE 19903
phone: (302) 736-4786
fax: (302) 735-6617

CSHN Director
Director (Vacant)
Child Health/CSHN
Division of Public Health
P.O. Box 637
Dover, DE 19903
phone: (302) 736-4786
fax: (302) 735-6617

DISTRICT OF COLUMBIA

MCH Directors
Patricia Tompkins, M.S., R.N.
Chief
Office of Maternal and Child Health
Commission of Public Health
Suite 907
1660 L Street, NW
Washington, DC 20036
phone: (202) 673-4551
fax: (202) 737-2386

Harry C. Lynch, M.D.
Chief
Bureau of Maternal and Child Health
Department of Human Services
Suite 904
1660 L Street, NW
Washington, DC 20036
phone: (202) 737-2386

CSHN Director
Jacqueline McMorris, M.D.
Acting Director
Health Services for Children with Special Needs
D.C. General Hospital, Bldg. 1 East
19th and Massachusetts Avenue, SE
Washington, DC 20003
phone: (202) 675-5214
fax: (202) 675-7694

FLORIDA

MCH Director
Donna Barber, R.N., M.P.H.
Chief
Health Program Policy and Development
Family Health Services
Florida Department of
Health/Rehabilitation Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
phone: (904) 487-1321
fax: (904) 488-2341

CSHN Director
J. Michael Cupoli, M.D.
Director
Children's Medical Services Program
Florida Department of
Health/Rehabilitation Services
Building 5, Room 129
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
phone: (904) 487-2690
fax: (904) 488-3813

GEORGIA

MCH Director
Virginia D. Floyd, M.D., M.P.H.
Director
Maternal and Child Health Branch
Georgia Department of Human
Resources
Division of Public Health
878 Peachtree Street, NE, Suite 217
Atlanta, GA 30309
phone: (404) 894-6622
fax: (404) 894-9487

CSHN Director
Rolando A. Thorne, M.P.H.
Acting Chief
Children's Health Services Section
Georgia Department of
Human Resources
Division of Physical Health
2600 Skyland Drive, NE, Lower Level
Atlanta, GA 30319
phone: (404) 679-0547
fax: (404) 679-0537

GUAM

Laurent Duenas
MCH/CSHN Director
Department of Public Health and
Social Services
P.O. Box 2816
Agana, GU 96910
phone: (671) 734-2083

HAWAII

MCH Directors
Eric Baumgartner, M.D., M.P.H.
Chief
Family Health Services Division
3652 Kilauea Avenue
Honolulu, HI 96816
phone: (808) 733-9017
fax: (808) 735-2141

Loretta Fuddy, A.C.S.W., M.P.H.
Acting Chief
Maternal and Child Health Branch
741-A Sunset Avenue
Honolulu, HI 96816
phone: (808) 733-9022
fax: (808) 733-9032

CSHN Directors
Alan N. Taniguchi, M.D., M.P.H.
Chief
Children with Special Health
Needs Branch
741 Sunset Avenue
Honolulu, HI 96816
phone: (808) 733-9070
fax: (808) 733-9068

Sachiko Taketa, R.N., M.P.H.
Chief
School Health Branch
741-A Sunset Avenue
Honolulu, HI 96816
phone: (808) 733-9040
fax: (808) 733-9032

IDAHO

MCH Director
Kathy Cohen
Acting Chief
Bureau of Maternal and Child Health
Idaho Department of Health/Welfare
450 West State Street
Boise, ID 83720
phone: (208) 334-5965
fax: (208) 334-5694

CSHN Director
Jeanie Scepka, R.N., B.S.N.
Program Manager
Children with Special
Health Needs Program
Bureau of Maternal and Child Health
Idaho Department of Health/Welfare
450 West State Street
Boise, ID 83720
phone: (208) 334-5963
fax: (208) 334-5964

ILLINOIS

MCH Director
Stephen E. Saunders, M.D., M.P.H.
Chief
Division of Family Health
Illinois Department of Public Health
535 West Jefferson Street
Springfield, IL 62761
phone: (217) 782-2736
fax: (217) 782-3987

CSHN Director
Robert Biehl, M.D.
Director
Division of Specialized
Care for Children
University of Illinois at Chicago
2815 West Washington, Suite 300
P.O. Box 19481
Springfield, IL 62794-9481
phone: (217) 793-2340
fax: (217) 793-0773

INDIANA

MCH Director
Judith Ganser, M.D., M.P.H.
Director
Maternal and Child Health Services
Indiana State Board of Health
1330 West Michigan Street
P.O. Box 1954
Indianapolis, IN 46204
phone: (317) 633-8451
fax: (317) 633-0776

CSHN Director
Sue Hornstein
Acting Director
Children's Special Health Care Services
Indiana State Board of Health
1330 West Michigan Street
P.O. Box 1964
Indianapolis, IN 46206-1964
phone: (317) 633-8456
fax: (317) 633-0757

IOWA

MCH Director
Charles Danielson, M.D., M.P.H.
Medical Director
Bureau of Family Services
Division of Family/Community Health
Iowa Department of Public Health
Lucas State Office Building
Des Moines, IA 50319-0075
phone: (515) 281-4912
fax: (515) 242-6384

CSHN Director
Richard P. Nelson, M.D.
Director
Iowa Child Health Specialty Clinic
University of Iowa
Iowa City, IA 52242
phone: (319) 356-1118
fax: (319) 356-3715

KANSAS

MCH Directors
Azzie Young, Ph.D.
Director
Bureau of Family Health
Kansas Department of Health
and Environment
Landon State Office Building
900 SW Jackson, 10th Floor
Topeka, KS 66612-1290
phone: (913) 296-1300
fax: (913) 296-4166

Linda Kenney, M.P.H.
Director
Children and Families Section
Bureau of Family Health
Kansas Department of
Health and Environment
Landon State Office Building
900 SW Jackson, 10th Floor
Topeka, KS 66612-1290
phone: (913) 296-1303
fax: (913) 296-4166

CSHN Director
Cassie Lauver, A.C.S.W.
Director
Services for Children with Special
Health Care Needs
Kansas Department of Health and
Environment
900 S.W. Jackson, 10th Floor
Topeka, KS 66612-1290
phone: (913) 296-1313
fax: (913) 296-4166

KENTUCKY

MCH Director
Patricia K. Nicol, M.D., M.P.H.
Director
Division of Maternal and Child Health
Kentucky Department of Human
Resources
275 East Main Street
Frankfort, KY 40621
phone: (502) 564-4830
fax: (502) 564-8389

CSHN Director
Denzle Hill, B.A., M.S., CCC-SP
Executive Director
Commission for Handicapped Children
Kentucky Department of Human
Resources
982 Eastern Parkway
Louisville, KY 40217
phone: (502) 588-3264
fax: (502) 588-4673

LOUISIANA

MCH Director
Joan Wightkin, M.P.H.
Administrator
Maternal and Child Health Section
Department of Health and Hospitals
P.O. Box 60630
New Orleans, LA 70160
phone: (504) 568-5073
fax: (504) 568-8162

CSHN Director
David Thomas, B.C.S.W.
Administrator
Handicapped Children's Services
Office of Public Health
Department of Health and Hospitals
P.O. Box 60630
New Orleans, LA 70160
phone: (504) 568-5055
fax: (504) 568-5507

MAINE

MCH Director
Zsolt Koppanyi, M.D., M.P.H.
Director
Division of Maternal and Child Health
Maine Department of Human Services
State House-Station 11
151 Capitol Street
Augusta, ME 04333
phone: (207) 289-3311
fax: (207) 289-4172

CSHN Director
Kathleen Burden
Director
Coordinated Care Services for
Children with Special Health Needs
Maine Department of Human Services
State House-Station 11
151 Capitol Street
Augusta, ME 04333
phone: (207) 289-3311
fax: (207) 289-4172

MARIANA ISLANDS

Berthillia John, R.N., B.S.N.
MCH/CSHN Director
Commonwealth of Northern
Mariana Islands
Department of Public Health and
Environment Services
Saipan, Commonwealth of Northern
Mariana Islands 96950
phone: (670) 234-8950

MARSHALL ISLANDS

Helen Jetnil, C.N.M.
Director of MCH/CSHN Program
Republic of the Marshall Islands
Majuro, Marshall Islands 96960
phone: (692) 625-3355

MARYLAND

MCH Directors
Polly Harrison, M.D.
Director
Child and Adolescent Health
Maryland Department of Health and
Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
phone: (410) 225-6749
fax: (410) 333-5995

Russell W. Moy, M.D., M.P.H.
Chief
Division of Maternal Health
Family Hereditary Disorders
Maryland Department of Health and
Mental Hygiene
201 West Preston Street, 3rd Floor
Baltimore, MD 21201
phone: (410) 225-6721
fax: (410) 333-5995

CSHN Director
Judson Force, M.D., M.P.H.
Chief
Division of Crippled Children Services
Maryland Department of Health and
Mental Hygiene
Mental Retardation/D D Administration
201 West Preston Street, 4th Floor
Baltimore, MD 21201
phone: (410) 225-5580
fax: (410) 333-5995

MASSACHUSETTS

Deborah Klein Walker, Ed.D.
Assistant Commissioner
Bureau of Parent/Child/Adolescent Health
Massachusetts Department of Public Health
150 Tremont Street, 4th Floor
Boston, MA 02111
phone: (617) 727-3372
fax: (617) 727-6496

MCH Director
Sally Fogergy, R.N.
Deputy Director
Bureau of Family/Community Health
Massachusetts Department of Public Health
150 Tremont Street, 2nd Floor
Boston, MA 02111
phone: (617) 727-3372
fax: (617) 727-6496

CSHN Director
Deborah Allen, M.S.
Director
Division for CSHN
Parent/Child/Adolescent Health
Massachusetts Department of Public Health
150 Tremont Street, 4th Floor
Boston, MA 02111
phone: (617) 727-6941
fax: (617) 727-6496

MICHIGAN

MCH Director
Terri D. Wright, M.P.H.
Chief
Bureau of Child and Family Services
Michigan Department of Public Health
3423 North Logan/M.L. King, Jr. Blvd.
P.O. Box 30195
Lansing, MI 48909
phone: (517) 335-8955
fax: (517) 335-8560

CSHN Director
Ronald Uken
Chief
Children's Special Health Care Services
Child and Family Services
Michigan Department of Public Health
P.O. Box 30195
Lansing, MI 48909
phone: (517) 335-8961
fax: (517) 335-8560

MICRONESIA

Sizuie Yoma, R.N., B.S.N.
MCH/CSHN Director
Department of Human Resources
Federated States of Micronesia
P.O. Box 490
Kolonia
Pohnpei FSM, 96941

MINNESOTA

MCH Director
Donna Petersen, M.H.S., Sc.D.
Director
Division of Maternal and Child Health
Minnesota Department of Health
717 Delaware Street, SE
P.O. Box 9441
Minneapolis, MN 55440
phone: (612) 623-5166
fax: (612) 623-5043

CSHN Director
Mary Wanninger
Acting Director
Services for Children with Handicaps
Minnesota Department of Health
717 Delaware Street, SE
P.O. Box 9441
Minneapolis, MN 55440
phone: (612) 623-5162
fax: (612) 623-5043

MISSISSIPPI

MCH Director
Kenneth P. Pittman, M.D.
Acting Director
Bureau of Health Services
Mississippi State Department of Health
2423 North State Street
P.O. Box 1700
Jackson, MS 39215-1700
phone: (601) 960-7480
fax: (601) 960-7852

CSHN Director
Sam Valentine
Director
Children's Medical Program
Mississippi State Department of Health
2423 North State Street
P.O. Box 1700
Jackson, MS 39215-1700
phone: (601) 987-3965
fax: (601) 987-5560

MISSOURI

Maureen Dempsey, M.D., F.A.A.P.
Interim Director
Division of Maternal, Child and Family Health
Missouri Department of Health
1738 East Elm Street
P.O. Box 570
Jefferson City, MO 65102
phone: (314) 751-6174
fax: (314) 751-6010

MONTANA

Maxine Ferguson, R.N., M.N.
Bureau Chief
Family/Maternal and Child Health Bureau
Montana Department of Health and Environmental Sciences
1400 Broadway, Room C314
Cogswell Building
Helena, MT 59620
phone: (406) 444-4743
fax: (406) 444-2606

NEBRASKA

MCH Director
David P. Schor, M.D.
Director
Division of Maternal and Child Health
Nebraska Department of Health
301 Centennial Mall South, 3rd Floor
Lincoln, NE 68509-5007
phone: (402) 471-2907
fax: (402) 471-0383

CSHN Director
Mary Jo Iwan
Administrator
Special Services for Children and Adults
Nebraska Department of Social Services
301 Centennial Mall South, 5th Floor
Lincoln, NE 68509-5026
phone: (402) 471-9345
fax: (402) 471-9455

NEVADA

Luana Ritch
Acting Chief
Family Health Services Bureau
Nevada State Health Division
505 East King Street, Room 205
Carson City, NV 89710
phone: (702) 687-4885
fax: (702) 687-3859

NEW HAMPSHIRE

Roger Taillefer, M.Ed.
Director
Office of Family and Community Health
New Hampshire Division of Public Health Services
6 Hazen Drive
Concord, NH 03301-6527
phone: (603) 271-4726
fax: (603) 271-3745

MCH Director
Charles Albano
Chief
Bureau of Maternal and Child Health
New Hampshire Division of Public Health Services
6 Hazen Drive
Concord, NH 03301-6527
phone: (603) 271-4517
fax: (603) 271-3745

CSHN Director
Jane Hybsch, R.N.
Chief
Bureau of Special Medical Services
New Hampshire Division of Public Health Services
6 Hazen Drive
Concord, NH 03301-6527
phone: (603) 271-4596
fax: (603) 271-3745

NEW JERSEY

Susan Lenox-Goldman
Assistant Commissioner
Division of Family Health Services
New Jersey Department of Health
363 West State Street, CN 364
Trenton, NJ 08625-0364
phone: (609) 292-4043
fax: (609) 292-3580

MCH Directors
Celeste F. Andriot, M.A.
Director
Community Health Services
Division of Family Health Services
New Jersey Department of Health
363 West State Street, CN 364
Trenton, NJ 08625-0364
phone: (609) 633-3666
fax: (609) 292-3580

Roberta McDonough, R.N., M.A.
Director
Parental and Child Health Services
New Jersey Department of Health
363 West State Street, CN 364
Trenton, NJ 08625-0360
phone: (609) 292-5656
fax: (609) 292-3580

CSHN Director
Barbara Kern, M.A.
Chief
Special Child Health Services
New Jersey Department of Health
363 West State Street, CN 364
Trenton, NJ 08625-0364
phone: (609) 984-0755
fax: (609) 292-3580

NEW MEXICO

Ann Taulbee, M.B.A.
Chief
Bureau of Maternal and Child Health
Department of Health
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502
phone: (505) 827-2350
fax: (505) 827-2329

CSHN Director
Marilyn Sakara, M.S.W.
Program Manager
Children's Medical Services
Department of Health and Environment
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502
phone: (505) 827-2350
fax: (505) 827-2329

NEW YORK

Lloyd F. Novick, M.D., M.P.H.
Director
Center for Community Health
New York Department of Health
Empire State Plaza
Corning Tower Building, Room 831
Albany, NY 12237
phone: (518) 474-3368
fax: (518) 474-4471

Monica Meyer, M.D.
Director
Division of Family Health
New York Department of Health
Bureau of Child and Adolescent Health
Empire State Plaza
Corning Tower Building, Room 780
Albany, NY 12237
phone: (518) 474-7922
fax: (518) 474-4471

Phyllis Silver
Child Advocate
Center for Community Health
New York Department of Health
Empire State Plaza
Corning Tower Building, Room 831
Albany, NY 12237
phone: (518) 473-7825
fax: (518) 474-7381

Michael Cohen, M.D.
Director
Bureau of Child/Adolescent Health
New York Department of Health
Empire State Plaza
Corning Tower Building, Room 780
Albany, NY 12237
phone: (518) 474-2084
fax: (518) 474-4471

NORTH CAROLINA

MCH Director
Ann Wolfe, M.D.
Director
Division of Maternal and Child Health
North Carolina Department of
Environment, Health, and
Natural Resources
P.O. Box 27687
Raleigh, NC 27611-7687
phone: (919) 733-3816
fax: (919) 733-2997

CSHN Director
Thomas J. Vitaglione, M.P.H.
Chief
Children and Youth Section
North Carolina Department of
Environment,
Health, and Natural Resources
P.O. Box 27687
Raleigh, NC 27611-7687
phone: (919) 733-7437
fax: (919) 733-2997

NORTH DAKOTA

MCH Director
David Cunningham
Director
Division of Maternal and Child Health
North Dakota Department of Health
State Capitol Building
600 East Boulevard Avenue
Bismarck, ND 58505
phone: (701) 224-2493
fax: (701) 224-3000

CSHN Director
Robert Nelson, M.S.W.
Administrator
Crippled Children's Services
North Dakota Department of Health
State Capitol Building
Judicial Wing
600 East Boulevard Avenue
Bismarck, ND 58505
phone: (701) 224-2436
fax: (701) 224-2359

OHIO

Kathryn K. Peppe, R.N., M.S.
Acting Chief
Division of Maternal and Child Health
Ohio Department of Health
246 North High Street, 7th Floor
P.O. Box 118
Columbus, OH 43266-0118
phone: (614) 466-3263
fax: (614) 644-8526

OKLAHOMA

MCH Director
Tisha Dowe Webb, M.D., M.P.H.
Acting Chief
Maternal and Child Health Medical Services
Oklahoma Department of Human Services
Oklahoma Department of Health
Room 703
1000 NE 10th Street
P.O. Box 53551
Oklahoma City, OK 73117-1299
phone: (405) 271-4476

CSHN Director
Raymond Haddock
Division Administrator
Children's Medical Services Division of Human Services
P.O. Box 25352
Oklahoma City, OK 73125
phone: (405) 557-2539
fax: (405) 528-4786

OREGON

MCH Director
Donna Clark, R.N.
Assistant Administrator
Office of Health Services
Oregon State Health Division
800 N.E. Oregon, #21
Portland, OR 97214-0450
phone: (503) 731-4016
fax: (503) 229-6519

CSHN Director
Clifford J. Sells, M.D.
Director
Child Development/Rehabilitation Center
Oregon Health Sciences University
P.O. Box 574
Portland, OR 97207
phone: (503) 494-8362
fax: (503) 494-4447

PALAU

Johana Ngiruchelbad
MCH/CSHN Director
Ministry of Health Services
Republic of Palau
MacDonald Memorial Hospital
P.O. Box 100
Koror, Palau 96940

PENNSYLVANIA

Judy Gallagher, R.N., Ed.M., M.P.A.
Director
Bureau of MCH Preventive Programs
Division of Maternal and Child Health
Pennsylvania Department of Health
Health and Welfare Building, Room 733
P.O. Box 90
Harrisburg, PA 17108
phone: (717) 787-7192
fax: (717) 783-3794

MCH Director
Daniel Brandt, M.S.W.
Acting Director
Division of Maternal and Child Health
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17108
phone: (717) 787-7440
fax: (717) 783-3794

CSHN Director
C. Gail Stock
Director
Division of Rehabilitative Services
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17108
phone: (717) 783-5436
fax: (717) 783-3794

PUERTO RICO

Carmen Feleciano, M.D., M.P.H.
Assistant Secretary
Family Health and Ambulatory Care
Commonwealth of Puerto Rico
Department of Health
Call Box 70184
San Juan, PR 00936
phone: (809) 765-6210
fax: (809) 766-1945

MCH Director
Roberto Varela-Flores, M.D., M.P.H.
Director
Maternal and Child Health
Commonwealth of Puerto Rico
Department of Health
Call Box 70184
San Juan, PR 00936
phone: (809) 754-9580
fax: (809) 766-1945

CSHN Director
Miquel Valencia-Prado, M.D.
Director
MCH and Children with Special Health Needs
Commonwealth of Puerto Rico
Department of Health
Call Box 70184
San Juan, PR 00936
phone: (809) 767-0870
fax: (809) 767-1945

RHODE ISLAND

MCH Director
William Hollinshead, M.D., M.P.H.
Director
Division of Family Health
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908-5098
phone: (401) 277-2312
fax: (401) 277-1442

CSHN Director
Peter Simon, M.D., M.P.H.
Assistant Medical Director
Division of Family Health
Rhode Island Department of Health
Three Capitol Hill, Room 302
Providence, RI 02908-5098
phone: (401) 277-2312
fax: (401) 277-1442

SOUTH CAROLINA

MCH Director
Marie C. Meglen, M.S., C.N.M.
Director
Bureau of Maternal and Child Health
South Carolina Department of Health and Environmental Control
Robert Mills Complex
P.O. Box 101106
Columbia, SC 29211
phone: (803) 737-4190
fax: (803) 734-4442

CSHN Director
Linda Price
Director
Division of Children's Rehabilitative Services
South Carolina Department of Health and Environmental Control
Robert Mills Complex
P.O. Box 101106
Columbia, SC 29211
phone: (803) 737-4050
fax: (803) 737-4078

SOUTH DAKOTA

Sandra Van Gerpen, M.D., M.P.H.
Assistant Secretary for Health and Medical Services
South Dakota Department of Health
445 East Capitol
Pierre, SD 57501-2080
phone: (605) 773-3737
fax: (605) 773-5509

TENNESSEE

MCH Director
Jeanece Seals, M.S., R.D.
Director
Maternal and Child Health Programs
Tennessee Department of Health and Environment
525 Cordell Hull Building
Nashville, TN 37247-4701
phone: (615) 741-0323
fax: (615) 741-2286

CSHN Director
Judith Womack, R.N.
Director
Children's Special Services
Tennessee Department of Health and Environment
525 Cordell Hull Building
Nashville, TN 37247-4701
phone: (615) 741-7353
fax: (615) 741-2491

TEXAS

MCH Director
Patti Patterson, M.D.
Chief
Bureau of Maternal and Child Health
Texas Department of Health
1100 West 49th Street
Austin, TX 78756-3179
phone: (512) 458-7700
fax: (512) 458-7350

CSHN Director
John E. Evans, M.H.A.
Chief
Bureau of Chronically Ill and Disabled Children Services
Texas Department of Health
1100 West 49th Street
Austin, TX 78756-3179
phone: (512) 458-7355
fax: (512) 458-7417

UTAH

C. Michael Fitzgerald, D.D.S., M.P.H.
Interim Director
Division of Family Health Services
Utah Department of Health
Cannon Building
288 North 1460 West
P.O. Box 16650
Salt Lake City, UT 84116-0650
phone: (801) 538-6161
fax: (801) 538-6510

MCH Directors
Thomas Wells, M.D., M.P.H.
Medical Affairs Advisor
Division of Family Health Services
Utah Department of Health
Cannon Building
288 North 1460 West
P.O. Box 16650
Salt Lake City, UT 84116-0650
phone: (801) 538-6853
fax: (801) 538-6510

Kathleen Glasheen, R.N., M.S.
Director
Child Health Bureau
Utah Department of Health
Cannon Building
288 North 1460 West
P.O. Box 16650
Salt Lake City, UT 84116-0650
phone: (801) 538-6140
fax: (801) 538-6510

CSHN Directors
George W. Delaven, M.D.
Acting Director
Maternal and Infant Health Bureau
Division of Family Health Services
Utah Department of Health
44 Medical Drive
Salt Lake City, UT 84113
phone: (801) 584-8239
fax: (801) 584-8488

Holly Balken, R.N., M.S.N.
Acting Director
Children's Special Health
Services Bureau
Division of Family Health Services
Utah Department of Health
Cannon Building
288 North 1460 West
P.O. Box 16650
Salt Lake City, UT 84116-0650
phone: (801) 538-6165
fax: (801) 538-6510

VERMONT

MCH Director
Paula Duncan, M.D.
Director
Maternal and Child Health
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05402
phone: (802) 863-7333
fax: (802) 863-7425

CSHN Director
Carol B. Hassler, M.D.
Director
Children with Special Health Needs
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05402
phone: (802) 863-7338
fax: (802) 863-7425

VIRGINIA

MCH Director
Alice Linyear, M.D.
Director
Bureau of Maternal and Child Health
Virginia Department of Health
1500 East Main Street
P.O. Box 2448
Richmond, VA 23218
phone: (804) 786-7367
fax: (804) 371-6031

CSHN Director
Nancy Bullock, R.N., M.P.H.
Director
Children's Specialty Services
Bureau of MCH
Virginia Department of Health
1500 East Main Street, Room 135
P.O. Box 2448
Richmond, VA 23218
phone: (804) 786-7367
fax: (804) 371-6031

VIRGIN ISLANDS

Olaf Hendricks, M.D.
Assistant Commissioner of Health
Virgin Islands Department of Health
516 Strand Street
Frederiksted, St. Croix, VI 00841
phone: (809) 772-5895

Mavis L. Matthew, M.D., M.P.H.
MCH Director
U.S. Virgin Islands Department of Health
Charles Harwood Hospital
North 3500 Estate Richmond
St. Croix, VI 00820-4370
phone: (804) 776-1311

WASHINGTON

MCH Director
Maxine Hayes, M.D., M.P.H.
Assistant Secretary
Division of Parent Child Health
Services
Department of Health
P.O. Box 47880
Olympia, WA 98504-7880
phone: (206) 753-7021
fax: (206) 586-3890

CSHN Director
Cathy Chapman, R.N., M.N.
Program Manager
Children with Special Health Needs
Division of Parent Health Services
Department of Health
P.O. Box 47880
Olympia, WA 98504-7880
phone: (206) 753-0908
fax: (206) 586-3890

WEST VIRGINIA

MCH Director
Pat Moss, M.S.W.
Director, Programs
Division of Maternal and Child Health
West Virginia Department of Health and
Human Services
1411 Virginia Street, East
Charleston, WV 25301
phone: (304) 348-5388
fax: (304) 348-2183

CSHN Director
Pat Kent, M.S.W.
Administrative Director
Division of Handicapped Children
West Virginia Department of Health and
Human Services
1116 Quarrier Street
Charleston, WV 25301
phone: (304) 558-3071
fax: (304) 558-2183

WISCONSIN

MCH Director
Richard A. Aronson, M.D.
Chief Medical Officer for MCH
Bureau of Public Health
Wisconsin Division of Health
P.O. Box 309
Madison, WI 53701-0309
phone: (608) 266-5818
fax: (608) 267-3824

CSHN Director
Gerard Simono
Supervisor CSHN
Wisconsin Division of Health
P.O. Box 309
Madison, WI 53701-0309
phone: (608) 266-3886
fax: (608) 267-1052

WYOMING

J. Richard Hillman, M.D., Ph.D.
Administrator
Family Health Services
Division of Health and Medical Services
Wyoming Department of Health
Hathaway Building
Cheyenne, WY 82002-0710
phone: (307) 777-6186
fax: (307) 777-5402

CSHN Director
John Harper
Manager
Children's Health Services
Division of Health and
Medical Services
Wyoming Department of Health
Hathaway Building
Cheyenne, WY 82002-0710
phone: (307) 777-7941
fax: (307) 777-5402

APPENDIX B
State Alcohol and Drug Agency Directors

ALABAMA

J. Kent Hunt
Acting Director
Division of Substance Abuse Services
Department of Mental Health and
Mental Retardation
200 Interstate Park Drive
P.O. Box 3710
Montgomery, AL 36193
phone: (205) 270-4650
fax: (205) 240-3195

ALASKA

Loren A. Jones
Director
Division of Alcoholism and Drug Abuse
Alaska Department of Health and
Social Services
P.O. Box 110607
Juneau, AK 99811-0607
phone: (907) 465-2071
fax: (907) 465-2185

ARIZONA

Ed Zborower
Acting Manager
Office of Substance Abuse/GMH
Division of Behavioral Health Services
Arizona Department of Health Services
2122 East Highland
Phoenix, AZ 85016
phone: (602) 381-8999
fax: (602) 553-9142

ARKANSAS

Joe M. Hill
Director
Arkansas Office of Alcohol and
Drug Abuse Prevention
Donaghey Plaza North, Suite 400
P.O. Box 1437
Little Rock, AR 72203-1437
phone: (501) 682-6650
fax: (501) 682-6610

CALIFORNIA

Andrew M. Mecca, Dr.P.H.
Director
Governor's Policy Council on Drug
and Alcohol Abuse
1700 K Street, 5th Floor
Executive Office
Sacramento, CA 95814-4037
phone: (916) 445-1943
fax: (916) 323-5873

COLORADO

Robert Aukerman
Director
Alcohol and Drug Abuse Division
Colorado Department of Health
4300 Cherry Creek Drive, South
Denver, CO 80222-1530
phone: (303) 692-2930
fax: (303) 782-4883

CONNECTICUT

John Higgins-Biddle, Ph.D.
Executive Director
Connecticut Alcohol and Drug Abuse
Commission
999 Asylum Avenue, 3rd Floor
Hartford, CT 06105
phone: (203) 566-4145
fax: (203) 566-6055

DELAWARE

Neil Meisler
Director
Delaware Division of Alcoholism
Drug Abuse and Mental Health
1901 N. DuPont Highway
Newcastle, DE 19720
phone: (302) 577-4461
fax: (302) 577-4486

DISTRICT OF COLUMBIA

Maude R. Holt
Administrator
Alcohol and Drug Abuse Services
Administration
1300 First Street, N.E., Suite 325
Washington, DC 20002
phone: (202) 727-1762
fax: (202) 727-5162

FLORIDA

Pamela Peterson
Deputy Assistant Secretary
Alcohol and Drug Abuse
Florida Department of Health and
Rehabilitation Services
1317 Winewood Boulevard
Building 6, Room 182
Tallahassee, FL 32301
phone: (904) 488-0900
fax: (904) 487-2239

GEORGIA

Patricia A. (Pam) Redmond
Director
Georgia Alcohol and Drug
Services Section
878 Peachtree Street, N.E., Suite 318
Atlanta, GA 30309
phone: (404) 894-4200
fax: (404) 853-0778

HAWAII

Elaine Wilson
Division Chief
Alcohol and Drug Abuse Division
Hawaii Department of Health
P.O. Box 3378
Honolulu, HI 96801
phone: (808) 586-3962
fax: (808) 586-4016

IDAHO

Ken Patterson
Administrator
Division of Family and Children
Services
Idaho Department of Health and Welfare
450 West State Street, 3rd floor
Boise, ID 83702
phone: (208) 334-5935
fax: (208) 334-5694

ILLINOIS

James E. Long
Director
Illinois Department of Alcoholism and
Substance Abuse
222 South College, 2nd Floor
Springfield, IL 62704
phone: (217) 785-9067
fax: (217) 785-0954

INDIANA

Johnie Underwood
Deputy Director
Division of Mental Health
Bureau of Addiction Services
W-353, 402 W. Washington Street
Indianapolis, IN 46204-2739
phone: (317) 232-7816
fax: (317) 233-3472

IOWA

Janet Zwick
Director
Division of Substance Abuse
Iowa Department of Public Health
Lucas State Office Building, 3rd Floor
Des Moines, IA 50319
phone: (515) 281-3641
fax: (515) 281-4958

KANSAS

Andrew O'Donovan
Commissioner
Kansas Alcohol and Drug Abuse Services
300 S.W. Oakley, Biddle Building
Topeka, KS 66606-1861
phone: (913) 296-3925
fax: (913) 296-0511

KENTUCKY

Michael Townsend
Director
Division of Substance Abuse
Kentucky Department of Mental Health
and Mental Retardation Services
275 East Main Street
Frankfort, KY 40621
phone: (502) 564-2880
fax: (502) 564-3844

LOUISIANA

Joseph Williams, Jr.
Assistant Secretary
Division of Alcohol and Drug Abuse
Department of Health and Hospitals
1201 Capitol Access Road
P.O. Box 2790
Baton Rouge, LA 70821-3868
phone: (504) 342-9354
fax: (504) 342-4419

MAINE

Marlene McMullen-Pelsor
Acting Director
Office of Substance Abuse
State House Station #159
24 Stone Street
Augusta, ME 04333-0159
phone: (207) 287-6330
fax: (207) 287-4334

MARYLAND

Rick Sampson
Director
Maryland State Alcohol and Drug
Abuse Administration
201 West Preston Street
Baltimore, MD 21201
phone: (410) 225-6925
fax: (410) 333-7206

MASSACHUSETTS

Dennis McCarty, Ph.D.
Director
Massachusetts Division of Substance
Abuse Services
150 Tremont Street
Boston, MA 02111
phone: (617) 727-7985
fax: (617) 727-9288

MICHIGAN

Karen Schrock
Chief
Center for Substance Abuse Services
Michigan Department of Public Health
3423 N. Logan/M. L. King Boulevard
P.O. Box 30195
Lansing, MI 48909
phone: (517) 335-8808
fax: (517) 335-8837

MINNESOTA

Cynthia Turnure, Ph.D.
Director
Chemical Dependency Program Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3823
phone: (612) 296-4610
fax: (612) 296-6244

MISSISSIPPI

Anne D. Robertson
Director
Division of Alcohol and Drug Abuse
Mississippi Department of Mental Health
Robert E. Lee State Office Building
11th Floor
Jackson, MS 39201
phone: (601) 359-1288
fax: (601) 359-6295

MISSOURI

Sue Giles
Director
Division of Alcohol and Drug Abuse
Missouri Department of Health
1706 E. Elm Street
Jefferson City, MO 65109
phone: (314) 751-4942
fax: (314) 751-7814

MONTANA

Darryl Bruno
Administrator
Alcohol and Drug Abuse Division
Department of Corrections and Human Services
1539 11th Avenue
Helena, MT 59601-1301
phone: (406) 444-2827
fax: (406) 444-4920

NEBRASKA

Malcolm Heard
Director
Division of Alcoholism and Drug Abuse
Nebraska Department of Public Institutions
P.O. Box 94728
Lincoln, NE 68509-4728
phone: (402) 471-2851, Ext. 5583
fax: (402) 479-5145

NEVADA

Liz Breshears
Chief
Bureau of Alcohol and Drug Abuse
Nevada Department of Human Resources
505 East King Street
Carson City, NV 89710
phone: (702) 687-4790
fax: (702) 687-4733

NEW HAMPSHIRE

Geraldine Sylvester
Director
New Hampshire Office of Alcohol and Drug Abuse Prevention
105 Pleasant Street
Concord, NH 03301
phone: (603) 271-6104
fax: (603) 271-6116

NEW JERSEY

Terrence O'Connor
Assistant Commissioner
Division of Alcoholism,
Drug Abuse and Addiction Services
New Jersey Department of Health
CN 362
Trenton, NJ 08625-0362
phone: (609) 292-5760
fax: (609) 292-3816

NEW MEXICO

Geraldine Salazar
Director
Department of Health
Behavioral Health Services Division/SA
Harold Runnels Building
Room 3200 North
1190 St. Francis Drive
Santa Fe, NM 87501
phone: (505) 827-2601
fax: (505) 827-0097

NEW YORK

Marquerite T. Saunders
Commissioner
New York State Office of Alcoholism
and Substance Abuse
P.O. Box 8200, Executive Park
Albany, NY 12203-8200
phone: (518) 474-5417 or
(518) 457-2061
fax: (518) 473-7652

John S. Gustafson
Deputy Director
New York Division of Substance
Abuse Services
Bureau of Government Relations
Executive Park South, Box 8200
Albany, NY 12203
phone: (518) 457-7629
fax: (518) 485-7198

NORTH CAROLINA

Flo Stein
Acting Director
Alcohol and Drug Abuse Section
North Carolina Division of Mental Health
and Mental Retardation Services
325 North Salisbury Street
Raleigh, NC 27611
phone: (919) 733-4670
fax: (919) 733-9455

NORTH DAKOTA

John Allen
Director
Division of Alcoholism and Drug Abuse
North Dakota Department of
Human Services
Professional Building
1839 East Capitol Ave
Bismarck, ND 58501
phone: (701) 224-2769
fax: (701) 224-3008

OHIO

Luceille Fleming
Director
Ohio Department of Alcohol and Drug
Addiction Services
Two Nationwide Plaza, 12th Floor
Columbus, OH 43216
phone: (614) 466-3445
fax: (614) 752-8645

OKLAHOMA

Paula Grove
Director
Substance Abuse Services
Oklahoma Department of Mental Health
and Substance Abuse Services
P.O Box 53277, Capitol Station
Oklahoma City, OK 73152
phone: (405) 271-8653
fax: (405) 271-7413

PENNSYLVANIA

Jeannine Peterson
Deputy Director
Office of Drug and Alcohol Programs
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17108
phone: (717) 787-9857
fax: (717) 772-6959

RHODE ISLAND

William Pimentel
Deputy Director
Rhode Island Office of Substance Abuse
P.O. Box 20363
Cranston, RI 02920
phone: (401) 464-2091
fax: (401) 464-2089

SOUTH CAROLINA

John W. Hays
Deputy Director
South Carolina Commission on
Alcohol and Drug Abuse
3700 Forest Drive
Columbia, SC 29204
phone: (803) 734-9527
fax: (803) 734-9663

SOUTH DAKOTA

Gilbert Sudbeck
Director
Division of Alcohol and Drug Abuse
Department of Human Services
Hillsview Plaza, East Highway 34
500 E. Capitol
Pierre, SD 57501-5090
phone: (605) 773-3123
fax: (605) 773-5483

TENNESSEE

Robbie Jackman
Assistant Commissioner
Bureau of Alcohol and Drug Abuse
Services
Tennessee Department of Health
Cordell Hull Building, Room 255
Nashville, TN 37247-4401
phone: (615) 741-1921
fax: (615) 741-2491

TEXAS

Bob Dickson
Executive Director
Texas Commission on Alcohol and
Drug Abuse
720 Brazos Street, Suite 403
Austin, TX 78701
phone: (512) 867-8802
fax: (512) 867-8181

UTAH

Leon PoVey
Director
Department of Social Services
Utah Division of Substance Abuse
120 North 200 West, 4th Floor
P.O. Box 45500
Salt Lake City, UT 84145-0500
phone: (801) 538-3939
fax: (801) 538-4016

VERMONT

Steven M. Gold
Interim Director
Vermont Office of Alcohol and Drug
Abuse Programs
103 South Main Street
Waterbury, VT 05676
phone: (802) 241-2170 or
(802) 241-2175
fax: (802) 241-2979

VIRGINIA

John F. Draude, Jr., Ph.D.
Director
Office of Substance Abuse Services
Virginia Department of Mental Health
Mental Retardation and Substance
Services
109 Governor Street
P.O. Box 1797
Richmond, VA 23214
phone: (804) 786-3906
fax: (804) 371-0091

WASHINGTON

Ken Stark
Director
Division of Alcohol and Substance Abuse
Washington Department of Social and Health Services
P.O. Box 45330
Olympia, WA 98504-5330
phone: (206) 438-8200
fax: (206) 438-8078

WEST VIRGINIA

Jack C. Clohan, Jr.
Director
West Virginia Division of Alcohol and Drug Abuse
State Capitol Complex
1900 Kanawha Boulevard
Building 3, Room 451
Charleston, WV 25305
phone: (304) 558-2276
fax: (304) 558-0045

WISCONSIN

Philip S. McCullough
Acting Director
Wisconsin Office of Alcohol and Other Drug Abuse
1 West Wilson St., P.O. Box 7851
Madison, WI 53707
phone: (608) 266-3719
fax: (608) 266-0036

WYOMING

Jean DeFratis
Director
Wyoming Alcohol and Drug Abuse Programs
Hathaway Building
Cheyenne, WY 82002
phone: (307) 777-6494
fax: (307) 777-5402

AMERICAN SAMOA

Fualaau Hanipale
Assistant Director
Social Services Division
Alcohol and Drug Program
Government of American Samoa
Pago Pago, AS 96799

Lefiga Liaiga
Director
Public Health Services
LBJ Tropical Medical
Pago Pago, AS 96799

GUAM

Marilyn L. Wingfield
Director
Department of Mental Health and Substance Abuse
P.O. Box 9400
Tamuning, GU 96911
phone: (671) 646-9262
fax: (671) 649-6948

PUERTO RICO

Astrid Oyola de Benitez
Secretary Designate
Puerto Rico Department of Anti-Addiction Services
Box 21414, Rio Piedras Station
Rio Piedras, PR 00928-1414
phone: (809) 764-3795
fax: (809) 765-5895

VIRGIN ISLANDS

Laurent D. Javois
Director
Virgin Islands Division of Mental Health Alcoholism and Drug Dependency Services Department of Health
Charles Harwood Memorial Hospital
Christianstead, St. Croix, VI 00820
phone: (809) 773-1992
fax: (809) 774-4701

APPENDIX C
State Child Welfare Commissioners/Directors

ALABAMA

Paul Vincent
Director
Family and Children's Services Division
Department of Human Resources
Gordon Persons Building
50 Ripley Street
Montgomery, AL 36130-1801
phone: (205) 242-9500
fax: (205) 242-1086

ALASKA

Deborah Wing
Director
Division of Family and Youth Services
Department of Health and
Social Services
P.O. Box 110630
Juneau, AK 99811-0630
phone: (907) 465-3191
fax: (907) 465-3190

ARIZONA

Linda Blessing
Deputy Director
Division of Social Services
Department of Economic Security
1789 West Jefferson Street
3rd Floor, South
P.O. Box 6123 (750A)
Phoenix, AZ 85005
phone: (602) 542-3598
fax: (602) 542-3330

ARKANSAS

Judith Faust
Assistant Director
Division of Children and Family Services
Department of Human Services
P.O. Box 1437, Slot #626
Little Rock, AR 72203
phone: (501) 682-6734

CALIFORNIA

Eloise Anderson
Director
Department of Social Services
Health and Welfare Agency
744 P Street
Sacramento, CA 95814
phone: (916) 657-2598
fax: (916) 653-1695

COLORADO

Susan Klein-Rothschild
Director
Child Welfare Services
Department of Social Services
1575 Sherman Street
Denver, CO 80203-1714
phone: (303) 866-3672
fax: (303) 866-2704

CONNECTICUT

Rose Alma Senatore
Commissioner
Department of Children and
Youth Services
170 Sigourney Street
Hartford, CT 06105
phone: (203) 566-3536
fax: (203) 566-7947

DELAWARE

Thomas P. Eichler
Secretary
Department of Services for Children,
Youth and Their Families
1825 Faulkland Road
Wilmington, DE 19805-1195
phone: (302) 633-2500
fax: (302) 633-2565

DISTRICT OF COLUMBIA

Clarice Dibble-Walker
Commissioner
Commission on Social Services
Department of Human Services
609 H Street, NE
Washington, DC 20002
phone: (202) 727-5930
fax: (202) 272-1687

FLORIDA

John Perry
Chief, Child Welfare
Bureau of Child Welfare
Children, Youth and Family
Program Office
Department of Health and
Rehabilitative Services
Building 8, Room 317
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
phone: (904) 488-8762
fax: (904) 488-9584

GEORGIA

Douglas Greenwell, Ph.D.
Director
Division of Family and Children's Service
Department of Human Resources
878 Peachtree Street, N.E.
Atlanta, GA 30309
phone: (404) 894-6386

HAWAII

Judy Nakano
Administrator
Family and Adult Services
Department of Human Services
P.O. Box 339
Honolulu, HI 96809
phone: (808) 334-5230

IDAHO

Ken Patterson
Administrator
Division of Family and
Children's Services
Department of Health and Welfare
450 W. State St.
Statehouse Mail
Boise, ID 83720
phone: (208) 334-5700
fax: (208) 334-5817

ILLINOIS

Sterling Ryder
Acting Director
Department of Children and
Family Services
406 East Monroe Street
Springfield, IL 62701
phone: (217) 785-2509
fax: (217) 785-1052

INDIANA

James Hmurobich
Director
Division of Families and Children
Family and Social Services
Administration
W362 Government Center South
402 W. Washington Street
Indianapolis, IN 46204
phone: (317) 232-4705
fax: (317) 232-0748

IOWA

Sally Titus Cunningham
Deputy Director
Office of Deputy Director for Services
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319
phone: (515) 281-5521

KANSAS

Carolyn Risley-Hill
Commissioner
Commission on Youth and Adult Services
Department of Social and
Rehabilitation Services
Smith-Wilson Building
300 S.W. Oakley Street
Topeka, KS 66606
phone: (913) 296-3284
fax: (913) 296-4649

KENTUCKY

Peggy Wallace
Commissioner
Department for Social Services
Cabinet for Human Resources
275 East Main Street
Frankfort, KY 40621
phone: (502) 564-4650

LOUISIANA

Brenda L. Kelley
Assistant Secretary
Office of Community Services
Department of Social Services
333 Laurel Street, 7th Floor
P.O. Box 3318
Baton Rouge, LA 70821
phone: (504) 342-2297
fax: (504) 342-2268

MAINE

Meris Bickford
Director
Bureau of Child and Family Services
Department of Human Services
221 State Street
Statehouse Station #11
Augusta, ME 04333
phone: (207) 289-2971

MARYLAND

Diane Gordy
Acting Executive Director
Social Services Administration
Department of Human Resources
Saratoga State Center
311 West Saratoga Street
Baltimore, MD 21201
phone: (410) 333-0102
fax: (410) 333-0099

MASSACHUSETTS

Linda Carlisle
Commissioner
Department of Social Services
Executive Office of Human Services
24 Farnsworth Street
Boston, MA 02210
phone: (617) 727-0900 ext. 502
fax: (617) 261-7435

MICHIGAN

Harold Gazan
Director
Children and Family Services
Family Services Division
Department of Social Services
235 South Grand Avenue
P.O. Box 30037
Lansing, MI 48909
phone: (517) 335-6158
fax: (517) 335-6177

MINNESOTA

Laura Skaff
Director
Family and Children's Services
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155
phone: (612) 296-6916

MISSISSIPPI

Joe Garvin
Director
Division of Family and Children's Services
Department of Human Services
939 N. President Drive, Room 201
Jackson, MS 39202
phone: (601) 354-6662
fax: (601) 354-6660

MISSOURI

Carmen Schulze
Director
Division of Family Services
Department of Social Services
615 Howerton Court
P.O. Box 88
Jefferson City, MO 65103
phone: (314) 751-4247
fax: (314) 751-8949

MONTANA

Hank Hudson
Director
Department of Family Services
48 North Last Chance Gulch
P.O. Box 8005
Helena, MT 59604
phone: (406) 444-5900
fax: (406) 444-5956

NEBRASKA

Chris Hanus-Schulenberg
Administrator
Human Services Division
Department of Social Services
301 Centennial Mall, South, 5th Floor
P.O. Box 95026
Lincoln, NE 68509-5026
phone: (402) 471-3121 ext. 1-9308

NEVADA

John Sarb
Administrator
Welfare Division
Department of Human Resources
2527 North Carson Street
Carson City, NV 89710
phone: (702) 687-5982
fax: (702) 687-4722

NEW HAMPSHIRE

Lorrie Lutz
Director
Division for Children and Youth Services
Department of Health and Human Services
6 Hazen Drive
Concord, NH 03301-6505
phone: (603) 271-4451

NEW JERSEY

Nicholas Scalera
Director
Division of Youth and Family Services
Department of Human Services
50 East State Street, CN717
Trenton, NJ 08625-0717
phone: (609) 292-6920
fax: (609) 984-0507

NEW MEXICO

Cynthia Forrester
Director
Social Services Division
Children, Youth and Families
Department
Pollon Plaza
2009 Pacheco Street
P.O. Box 2348
Santa Fe, NM 87504-2348
phone: (505) 827-8400
fax: (505) 827-8480

NEW YORK

Jim Purcell
Associate Commissioner
Division of Family and Children Services
Department of Social Services
40 North Pearl Street
Albany, NY 12243
phone: (518) 474-9428
fax: (518) 424-1842

NORTH CAROLINA

Mary K. Deyampert
Director
Division of Social Services
Department of Human Resources
325 North Salisbury Street
Raleigh, NC 27603
phone: (919) 733-3055
fax: (919) 733-7058

NORTH DAKOTA

Donald Schmid
Director
Children and Family Services Division
Office of Field Services and
Program Development
Department of Human Services
State Capitol—Judicial Wing
600 East Boulevard
Bismarck, ND 58505
phone: (701) 224-2316

OHIO

Jann Heffner
Deputy Director
Child Care and Family Services
Department of Human Services
30 East Broad Street, 32nd Floor
Columbus, OH 43266-0423
phone: (614) 466-1213
fax: (614) 466-9247

OKLAHOMA

Jim Angle
Division Administrator
Division of Children and Youth Services
Department of Human Services
P.O. Box 25352
Oklahoma City, OK 73125
phone: (405) 521-4088

OREGON

Bill Carey
Administrator
Children's Services Division
Department of Human Resources
198 Commercial Street, S.E.
Salem, OR 97310
phone: (503) 378-4374
fax: (503) 581-6198

PENNSYLVANIA

George B. Taylor
Deputy Secretary
Office of Children, Youth, and Families
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675
phone: (717) 787-4756
fax: (717) 787-0414

RHODE ISLAND

Linda D'Amario Rossi
Director
Department for Children, Youth and Families
610 Mt. Pleasant Avenue
Providence, RI 02908-1935
phone: (401) 457-4750
fax: (401) 457-5363

SOUTH CAROLINA

William E. Middleton
Deputy Commissioner
Office of Human Services and Self Sufficiency
Department of Social Services
1531 Confederate Avenue
P.O. Box 1520
Columbia, SC 29202-1520
phone: (803) 734-6182
fax: (803) 734-5597

SOUTH DAKOTA

Judy Barnes
Program Administrator
Office of Program Management
Department of Social Services
700 Governors Drive
Pierre, SD 57501
phone: (605) 773-3227

TENNESSEE

Betty Gayle
Assistant Commissioner
Social Services
Department of Human Services
Citizens Plaza
400 Deaderick Street
Nashville, TN 37248-0001
phone: (615) 741-1442

TEXAS

Janice Caldwell, Ph.D.
Executive Director
Department of Protective and Regulatory Services
Health and Human Services Commission
701 West 51st Street
P.O. Box 149030, W-639
Austin, TX 78714-9030
phone: (512) 450-4778

UTAH

Barbara Thompson
Director
Division of Family Services
Department of Human Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
phone: (801) 538-4100
fax: (801) 538-4016

VERMONT

William M. Young
Commissioner
Department of Social and Rehabilitation Services
Agency of Human Services
103 South Main Street
Waterbury, VT 05676
phone: (802) 241-2101
fax: (802) 241-2830

VIRGINIA

Ray Goodwin
Deputy Commissioner
Local Programs
Department of Social Services
8007 Discovery Drive
Richmond, VA 23299-8699
phone: (804) 662-7091

WASHINGTON

Jean Soliz
Assistant Secretary
Children, Youth and Family Services
Department of Social and Health Services
State Office Building
Mail Stop OB-44B
Olympia, WA 98504
phone: (206) 586-4031
fax: (206) 586-5874

WEST VIRGINIA

Garrett Moran, Ph.D.
Commissioner
Office of Community Support
Department of Health and Human
Resources, Building 6
State Capitol Complex
Charleston, WV 25305
phone: (304) 348-2400

WISCONSIN

Gerald Born
Administrator
Division of Community Services
Department of Health and
Social Services
1 West Wilson Street
Madison, WI 53707-7851
phone: (608) 266-2701

WYOMING

K. Gary Sherman
Director
Department of Family Services
Hathaway Building, Room 347
2300 Capitol Avenue
Cheyenne, WY 82002
phone: (307) 777-5831
fax: (307) 777-7747

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